HEALTH SCREENING CONSENT FORM

BD06

First Name (required)

Last Name (required)

Street Address

City

State

Zip

Phone Number(required)

Date of Birth (required):

(Month) (Day) (Year)

Gender (circle): F M

E-mail address

Member ID

Group #/ID

I wish to participate in the screening program being offered by US Wellness, Inc. By signing this consent form, I understand that I am requesting and agree to allow US Wellness to perform the screening.

- I understand that a screening does not replace a consultation, physical examination, or evaluation from my physician or other appropriate healthcare provider.
- I understand that this screening may generate an inaccurate result. I will discuss my screening results with my physician and will not use my result as an indicator for medication dosing, such as insulin.
- I understand that the recommendation to contact my physician about the result of the screening is not a medical diagnosis or assessment of good health as only my own physician can make such a judgment and more information would be needed to establish or rule out a diagnosis or assessment of good health.
- I understand that participation in this screening will not protect me from disease.
- I understand that regardless of the results of this screening and consultation, my overall health is affected by cigarette smoking, family history of disease, hypertension and excess weight, and that I should discuss these risk factors with my own physician.
- I understand that I am responsible for any follow-up examinations with my physician that may be indicated from the results of this screening.

I hereby release US Wellness, Inc. and OptumHealth Care Solutions, Inc. their affiliated and subsidiary companies, divisions, directors, officers, employees, agents and contractors and any and all other organizations involved in the program, and their affiliates and subsidiaries, and all of their past and present officers, employees and agents, and the successors of each, from any liability and responsibility for any and all manner of actions, causes of action, (individual and class), claims or demands of any kind whatsoever, whether known, suspected or unknown, in law or in equity including, but not limited to, all claims or potential claims arising out of my voluntary participation in or any injury, loss or death sustained from or arising as a result of, this screening program, and any claim that this screening failed to identify or incorrectly identified any health condition. I acknowledge that I am not a Medicare member nor will I seek reimbursement for these services from Medicare. Medicare members should request these services from their primary care physician. By signing below, I acknowledge that I have read, understand, and accept all of the statements on this consent form.

Signature of Participant

Date

HbA1C is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months. It shows how well you are controlling your diabetes. To help manage A1C, limit processed and refined grains and excess carbohydrates. If you drink alcohol, drink in moderation. Limit or avoid sugary drinks such as soda, sweet tea, lemonade or any drink with added sugar. Exercise 30 minutes a day or more.

A1c Device Serial Number

Height: (Feet) (Inches)

Weight: (Pounds)

Your HbA1c: . %

Normal 0% to 5.6%
Pre-diabetes :5.7% to 6.4%
High Risk for Diabetes :6.5% or Greater

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Health Screener Signature:_____